

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-012960

STATE FILE NUMBER

FILED APR 27 1959

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 386A

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		c. CITY OR TOWN Springfield 6396	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hospital		d. STREET ADDRESS (If outside, give location) 820 N. Prospect	
3. NAME OF DECEASED (Type or print) First MARY Middle CATHERINE Last KINCADE		4. DATE OF DEATH Month April Day 11 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 8, 1959
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		11. BIRTHPLACE (City and state or country) Springfield, Mo.	
13a. FATHER'S NAME Robert S. Kincade		14. NAME OF HUSBAND OR WIFE none	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital Peritonitis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 7680		12. CITIZEN OF WHAT COUNTRY? USA	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 7680	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION Springfield	
21. I attended the deceased from _____ Death occurred at _____		22a. SIGNATURE <i>Effie G. Melton</i> (Deceased or title)	
22b. ADDRESS 1715 Boonville Springfield Mo		22c. DATE SIGNED 4-15-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-13-59	
23c. NAME OF CEMETERY OR CREMATORY East Lawn Cemetery		23d. LOCATION (City, town, or county) (State) Springfield Missouri	
24. FUNERAL DIRECTOR Ralph Thieme, Springfield, Mo.		25. DATE RECD. BY LOCAL REG. 4-23-59	
26. REGISTRAR'S SIGNATURE <i>Effie G. Melton</i>			

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Locust, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed 

Licensed Embalmer No. 4568
Springfield, Mo.
P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.